

**PHYSICIAN
PAYMENT
REVIEW
COMMISSION**

**THE ROLE OF
SPECIALTY SOCIETIES
AND PHYSICIANS
IN THE
COMMISSION'S
EVALUATION OF
RELATIVE
WORK VALUES**

No. 91-7

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PREFACE

This report is one in a series describing the Commission's work in evaluating relative work values to be used in the Medicare Fee Schedule. The findings described in these reports contributed to the recommendations submitted to Congress over the last three years about needed refinements in the scale of relative work.

Vicky Pebsworth and Teresa DeCaro authored this report. With Roz Lasker, they were the Commission staff members principally responsible for this project. Jim Bahr and Katie Merrell assisted in the development of the database, and David Shapiro and Maureen Morrow participated in planning and facilitating the meeting of the Interspecialty Advisory Panel.

CONTENTS

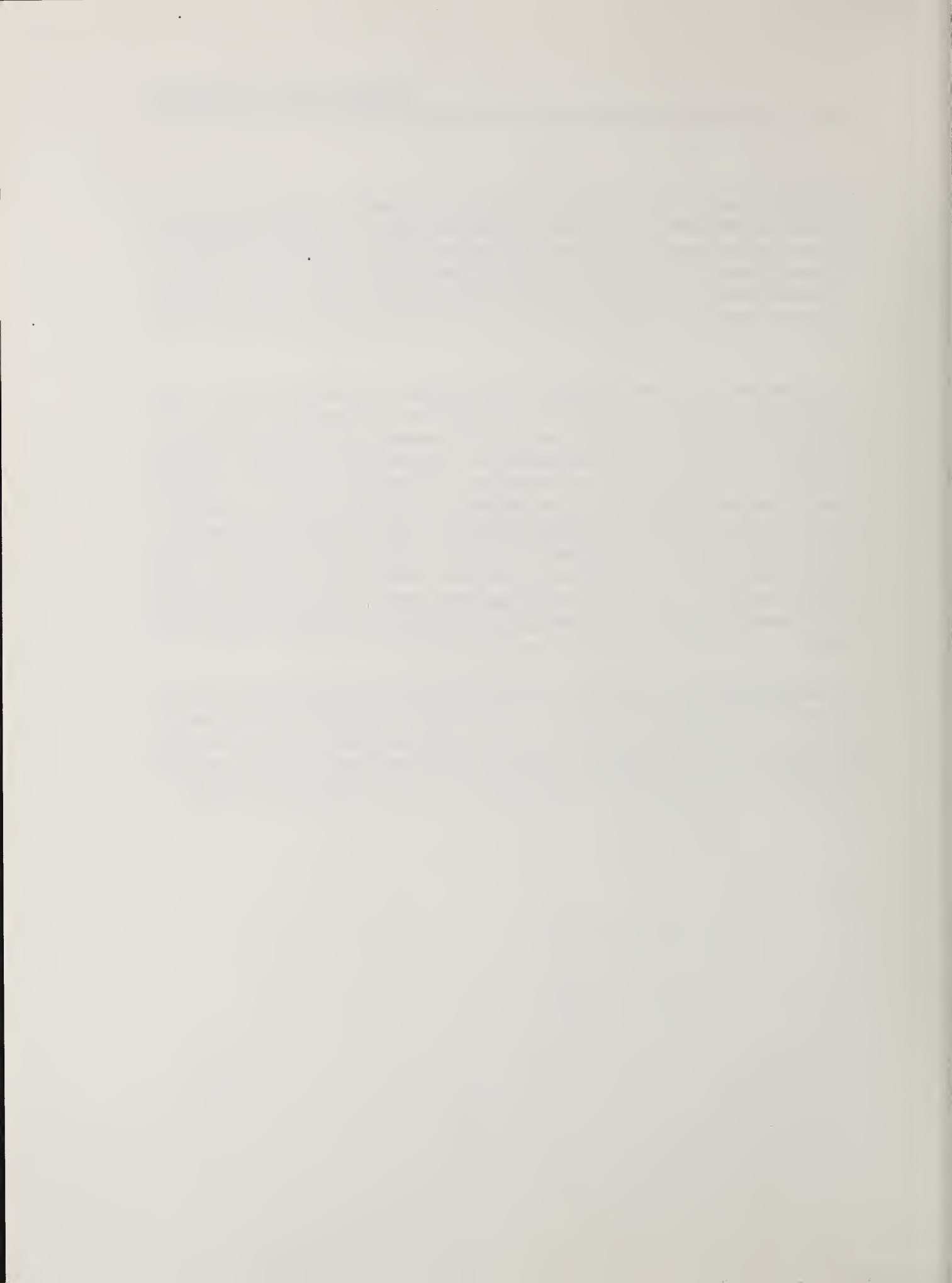
	Page
Preface	i
Executive Summary	iii
The Role of Specialty Societies and Physicians in the Commission's Evaluation of Relative Work Values	1
Specialty Society Comments	2
Interspecialty Advisory Panel	6
Other Issues Addressed by Specialty Societies	25
Appendixes	
A Commission Recommendations for Refining the Scale of Relative Work	29
B Specialty Societies Invited to Participate in the Refinement Process	32
C Materials Mailed to Specialty Societies to Review Non-Radiology RWVs and Cross-Specialty Linkages	34
Instructions	
Response Forms	
Sample of RWVs	
Sample of Cross-Specialty Linkages	
D Materials Mailed to Specialty Societies to Review Radiology RWVs	44
Instructions	
Response Forms	
Sample of RWVs	
Sample of Master List of Hsiao and RFS Values	
E CPT Codes for RWVs Disputed by Societies, By Type of Service	52
Tables	
1 Frequency with which Hsiao Total RWVs were Disputed and Ratios of Specialty's Proposed RWVs to Hsiao RWVs, by Specialty	4
2 Frequency with which Hsiao Total RWVs were Disputed and Ratios of Proposed RWVs to Hsiao RWVs, by Type of Service	5
3 Interspecialty Advisory Subpanels	8
4 Demographic Characteristics of the Interspecialty Panel	9

EXECUTIVE SUMMARY

An accurate scale of relative work is a key factor in assuring equitable payment for physician services under the Medicare Fee Schedule (MFS). In comments provided to Congress and the Health Care Financing Administration on the June 5, 1991 Notice of Proposed Rulemaking for the MFS, the Commission made recommendations concerning refinements needed to improve the scale of relative work (PPRC 1991c). Specialty societies and physicians contributed substantially to the Commission's work that led to this report.

The Commission solicited comments from specialty societies about the clinical reasonableness of the relative work values (RWVs) and cross-specialty links that were released after Phase II of the Hsiao study. Overall, specialty societies were satisfied with the majority of RWVs for their surveyed codes. Analysis of their comments, however, identified the following eight issues affecting broad categories of RWVs: 1) problems related to the categorization of invasive services; 2) assignment of pre- and postservice work for non-global services; 3) assigning intraservice work for surgical global services; 4) the effect of patient age on relative work; 5) the effect of factors other than age on relative work; 6) problems related to vignettes; 7) problems related to CPT coding, and 8) the assignment of RWVs to evaluation and management services. The Commission convened an interspecialty panel of 42 physicians and limited licensed practitioners to explore each of these issues in detail and to discuss potential solutions.

This report begins with a description of the specialty societies' comments and the structure and function of the interspecialty panel. It then presents a summary of each issue, the charge to the interspecialty panel, and the panel's findings. Finally, there is a description of two additional issues identified by specialty societies that were not brought before the interspecialty panel meeting including, radiology RWVs and cross-specialty linkages.



THE ROLE OF SPECIALTY SOCIETIES AND PHYSICIANS IN THE COMMISSION'S EVALUATION OF RELATIVE WORK VALUES

An accurate scale of relative work is a key factor in assuring equitable payment for physician services under the Medicare Fee Schedule. The most current relative work values (RWVs) available for review are contained in the Notice of Proposed Rulemaking (NPRM) for the Medicare Fee Schedule issued by the Health Care Financing Administration (HCFA) on June 5, 1991. These RWVs reflect research conducted by Professor William Hsiao and his colleagues at Harvard University (Hsiao study), HCFA's Medicare payment policies, and the Current Procedural Terminology (CPT) coding system of the American Medical Association.

In comments provided to HCFA on the NPRM (PPRC 1991c), the Commission made recommendations concerning refinements needed to improve the scale of relative work (Appendix A). These recommendations reflect more than three years of work that involved exchanging information and comments with the Hsiao research team and HCFA staff, evaluating the methodology and results of Phases I, II and III of the Hsiao study (Hsiao 1988, 1990),¹ comparing data from the Hsiao study with data from other related research studies,² analyzing comments from specialty societies,³ convening an interspecialty panel of physicians to consider a series of issues raised in specialty society comments, and reviewing the NPRM for the Medicare Fee Schedule.

This report focuses on the important contribution of physicians and specialty societies to the Commission's evaluation of the scale of relative work. Their perspectives were solicited to help the Commission assess the clinical reasonableness of RWVs and cross-specialty linkages. The Commission's comments on the NPRM reflect, to a great extent, comments provided to it by medical specialty societies and the interspecialty panel of physicians. The work of the panel and specialty societies helped the Commission identify and evaluate broad categories of Phase II RWVs that appeared inaccurate, the underlying

¹ Lewin/ICF, Inc. (Allen Dobson, Ph.D., Vice President and principal investigator) and Susan Marquis, Ph.D., senior economist at the RAND Corporation worked with the Commission on the Hsiao study evaluation. The research protocols being used by the Harvard researchers in Phase III have not yet been made available to the Commission for review. In addition, the small-group process approach used in Phase III has not yet been evaluated.

² The research studies included a survey of cardiothoracic and vascular surgeons conducted by Abt Associates, Inc. (Noether 1990), the Commission's Visit Survey and Surgical Global Service Project. Susan Marquis, Ph.D., senior economist at the RAND Corporation and Monica Noether, Ph.D, vice president of Abt Associates Inc, worked with the Commission on the Visit Survey and Global Surgical Project, respectively.

³ Comments from specialty societies were shared with William Hsiao and his colleagues, as well as analysts from the Health Care Financing Administration (HCFA), and the American Medical Association (AMA).

problems affecting the accuracy of those RWVs, and various policy options to correct them.

SPECIALTY SOCIETY COMMENTS

The Commission asked specialty societies to comment on the RWVs for individual services. It chose to use that information not to propose adjustments in individual RWVs, but to determine whether generic problems existed that systematically affected broad groups of services. Because this approach could potentially affect large numbers of services, the Commission believed that identifying and correcting systematic problems was a higher priority than refining individual RWVs that were inaccurate for idiosyncratic reasons.

To evaluate the scale of relative work, the Commission asked physicians to participate in assessing the clinical reasonableness of RWVs and cross-specialty linkages. In December 1990, 62 societies and other organizations (Appendix B) representing physicians and limited license practitioners in 41 specialties were sent instructions, lists of RWVs and cross-specialty links, and response forms to evaluate their values and links (Appendix C). They were asked to provide an alternative value and rationale when RWVs were considered inaccurate. They were also asked to comment on their cross-specialty links, the Radiologists' Fee Schedule (RFS) and the method proposed by the Commission to link radiology services to Hsiao's common scale (Appendix D).⁴

Commission staff responded to requests for information and assistance from specialty societies, their members and consultants working with them. The staff also contacted all societies that did not respond by the due date to offer assistance and to encourage participation in the refinement process.

By early April, 75 percent of all societies commented on RWVs and cross-specialty linkages, while 40 percent commented on radiology RWVs and the proposed linking

⁴ RWVs for evaluation and management services were not included in this step of the refinement process because codes for visits and consultations were being revised. Societies were not asked to review RWVs for anesthesia services because the Medicare Fee Schedule payment for these services will be based on the Anesthesia Uniform Relative Value Guide. The societies representing dermatology, pathology, psychiatry, and ophthalmology received RWVs for their services in January 1991, when the results of the resurveys for these specialties were released by Professor Hsiao.

method.⁵ Some specialties were represented by more than one society. Because of this, while not all societies responded, 90 percent of the specialties surveyed in the Hsiao study had at least one society that submitted comments on non-radiology RWVs and cross-specialty linkages.⁶

Twelve specialties were directly surveyed about radiology services in the Hsiao study and societies representing 10 of these specialties submitted comments.⁷ Some societies whose specialties were not surveyed for radiology services in the Hsiao study also provided comments about RFS values, Hsiao radiology RWVs, and the method proposed by the Commission to link the RFS with the Hsiao common scale. In total, societies representing 20 specialties submitted comments about radiology issues.

Overall, specialty societies were satisfied with the majority of RWVs for their surveyed codes. When RWVs were disputed, however, the comments made by societies and the magnitude of the changes they requested suggested that there were serious problems underlying the RWVs for some groups of services.

Societies disputed and proposed alternative RWVs for 38 percent of the 341 services they were asked to review (Table 1). Of the RWVs questioned, there was consensus among societies that 59 percent of the Hsiao study RWVs were too low and 4 percent were too high. The remaining 37 percent of RWVs were disputed by at least one of two or more responding societies, but there was not consensus among all societies commenting on a particular RWV about whether that RWV should be changed, or in which direction (Appendix E). Generally, when there was not consensus among societies about a RWV, one society felt the RWV was too low and the other was implicitly satisfied with it.⁸

⁵ The Commission solicited comments on RWVs for 341 CPT codes and received comments from specialty societies on 321 codes (94 percent). The information provided permitted analysis according to society, specialty, type of specialty (medicine, surgery, primary care and miscellaneous), and type of service (laboratory services, surgical global services, diagnostic procedures and technical procedures). Because specialty societies were asked to comment only on unsatisfactory Phase II RWVs, any RWVs not explicitly commented upon were assumed to be satisfactory and so noted in the database. Ultimately, over 2,700 comments were coded and entered into the database.

⁶ Comments were not received from societies representing psychiatry. The Commission did not receive comments from societies representing plastic surgery in time to be used in this analysis.

⁷ Specialties surveyed about radiology services included dermatology, diagnostic radiology, neurology, nuclear medicine, obstetrics and gynecology, ophthalmology, oral and maxillofacial surgery, orthopaedic surgery, psychiatry, pulmonary medicine, radiation oncology and rheumatology. Comments were not received from societies representing pulmonary medicine and psychiatry.

⁸ When there was consensus among responding societies about the direction of change, the Hsiao RWV for a given code was noted as "too low" or "too high". Likewise, "satisfactory" Hsiao RWVs were those not disputed by any responding societies. Lack of consensus among societies occurred both within and between specialties.

Table 1. Frequency with which Hsiao Total RWVs were Disputed, and Ratios of Specialty's Proposed RWVs to Hsiao RWVs, by Specialty

Specialty	Number of RWVs Reviewed	Number (Percent) of RWVs Disputed		Specialty's Proposed RWV Hsiao Total RWV	
				Range	Mean
Allergy and Immunology	9	0	(0%)	1.00	1.00
Anesthesia	2	1	(50)	1.00 - 3.06	2.03
Cardiology	13	6	(46)	.53 - 1.96	1.07
Dermatology	40	11	(28)	1.00 - 1.33	1.09
Emergency Medicine	14	4	(29)	1.00 - 3.31	1.23
Family Practice	8	2	(25)	1.00 - 1.22	1.04
Gastroenterology	16	14	(88)	.85 - 1.43	1.09
General Surgery	39	39	(100)	1.07 - 2.23	1.25
Hematology/Oncology	7	4	(57)	1.00 - 1.95	1.18
Infectious Disease	5	0	(0)	1.00	1.00
Internal Medicine	7	1	(14)	.46 - 1.00	.96
Oral/Maxillofacial Surgery	13	6	(46)	1.00 - 1.55	1.09
Nephrology	4	1	(25)	1.00 - 1.61	1.15
Neurology	7	6	(86)	1.00 - 1.76	1.44
Neurosurgery	16	3	(19)	1.00 - 1.24	1.03
Obstetrics/Gynecology	11	4	(36)	1.00 - 1.24	1.07
Ophthalmology	53	0	(0)	1.00	1.00
Orthopaedic Surgery	46	6	(13)	1.00 - 1.81	1.01
Osteopathic Medicine	7	0	(0)	1.00	1.00
Otolaryngology	17	11	(65)	.73 - 2.40	1.29
Pathology	21	10	(48)	1.00 - 1.91	1.09
Pediatrics	7	4	(57)	1.00 - 1.48	1.18
Physical and Rehabilitative Medicine	7	0	(0)	1.00	1.00
Pulmonary	7	3	(43)	.64 - 1.67	1.02
Rheumatology	5	0	(0)	1.00	1.00
Cardiothoracic and Vascular Surgery	13	13	(100)	.57 - 2.08	1.22
Urology	14	4	(21)	1.00 - 1.80	1.08
All Specialties	341	153	(38)	.46 - 3.31	1.08

Notes: Specialties reflect those surveyed in the Hsiao study for non-radiology services that submitted comments on RWVs. Analysis of responses for societies representing optometry and podiatry are included under the specialties of ophthalmology and orthopedic surgery, respectively. Comments about ophthalmology services were provided only by the optometry society.

RWVs for vignettes that were not matched to CPT codes are excluded from this analysis.

The ratio reflects the proposed mean when more than one society within a specialty proposed a RWV.

A Hsiao RWV for a given service that was judged to be underestimated is noted by a ratio >1.0. Conversely, a RWV for a service judged to be overestimated is noted by a ratio <1.0.

Number of RWVs disputed is >131 because some RWVs were reviewed by societies in multiple specialties.

Note that proposed changes were small overall, but very substantial, up to three fold, for individual services (Tables 1 and 2). For example, some RWVs for technical procedures and surgical global services were judged to be overestimated by 100 percent while others were considered underestimated by 240 percent or more (Table 2).⁹ No diagnostic procedures or laboratory services, on the other hand, were judged to be overestimated.¹⁰ For technical and diagnostic procedures, at least 75 percent of disputed RWVs were judged to be inaccurate by 20 percent or more. This compares to 58 percent for laboratory and 43 percent for surgical global services.

Table 2. Frequency with which Hsiao Total RWVs were Disputed and Ratios of Proposed RWVs to Hsiao RWVs, by Type of Service

Type of Service	Number of RWVs Reviewed	Number (Percent) of RWVs Disputed	<u>Specialty's Proposed RWV</u> Hsiao Total RWV	
			Range	Mean
Diagnostic Procedure	25	5 (20%)	1.0 - 1.27	1.01
Laboratory	42	17 (40)	1.0 - 1.96	1.13
Surgical Global	172	64 (37)	.57 - 2.40	1.07
Technical Procedure	102	45 (44)	.46 - 3.31	1.09
All Services	341	131 (38)	.46 - 3.31	1.08

Note: Mean and range reflect individual society disputes with RWV's. Data was not aggregated to the specialty level.

⁹ The types of services in this analysis are defined as follows. Diagnostic procedures are generally non-invasive, primarily used for diagnostic purposes, and performed by physicians (for example, fluorescein angiography). When diagnostic procedures are invasive they involve needle punctures and not incisions except to attain intravascular access (for example, lumbar punctures and cardiac catheterizations). Technical procedures are generally performed for therapeutic purposes (but may also be diagnostic) and typically are invasive but do not involve deep surgical incisions (for example, chest tube insertions or endoscopic procedures). Laboratory services include review of reports for tests such as electroencephalograms typically performed by technicians.

¹⁰ Despite this variation, the mean of ratios by type of service is 1.08 because the majority of Hsiao RWVs was judged to be satisfactory.

Cluster analysis of the societies' comments and the results of other Commission work to evaluate RWVs were used to determine whether specific criticisms fell into a set of broad issues that could later be addressed by the interspecialty panel of physicians. Most of the societies' comments on non-evaluation and management services fell into one of four major themes which included problems with vignettes, CPT coding, pre- and postservice work, or factors affecting the intensity of work. At least one of these four themes was cited as a reason for dissatisfaction for 85 percent of disputed RWVs, with two or more of these problems cited for approximately half of the disputed RWVs. Specialty society comments from a separate solicitation regarding the findings of the Commission's Visit Survey were analyzed to identify issues related to evaluation and management (EM) services.

To specify the issues and questions to be brought to the interspecialty panel of physicians, the Commission staff analyzed specialty society comments on EM services and on the four broad themes identified through its cluster analysis as well as findings and data from its evaluation of the Hsiao study and the Abt study, the Commission's Visit Survey, and its Surgical Global Service Project.¹¹

Eventually eight issues were selected by the Commission for discussion by the physicians on the interspecialty panel: 1) the categorization of invasive services; 2) the assignment of pre- and postservice work for non-global procedures; 3) the assignment of intraservice pre- and postincisional work; 4) the effect of patient age on the scale of relative work; 5) the effect of other factors such as severity of illness on the scale of relative work; 6) problems related to vignettes; 7) problems related to CPT coding; and 8) the assignment of RWVs for EM services.

INTERSPECIALTY ADVISORY PANEL

The Commission has previously convened panels of physicians to draw on their clinical expertise and judgement in analyzing issues and developing policy recommendations. Their involvement is particularly important on issues that cannot be resolved on the basis of empirical data alone. The eight issues noted above represent just those types of issues and, for this reason the Commission convened an interspecialty panel of physicians to advise it on possible policy solutions.

¹¹ Two of the broad themes were composites of several distinct issues. Problems with pre- and postservice work are related to three distinct issues: the categorization of invasive services, the assignment of pre- and postservice work for non-global procedures, and the assignment of intraservice pre- and postincisional work. Problems related to the intensity of work were sorted into two groups: the effect of patient age on the scale of relative work, and the effect of other factors such as severity of illness on the scale of relative work.

The interspecialty panel met in Washington, DC on May 15-17, 1991. It consisted of 42 physicians and limited license practitioners representing 41 specialties (Table 3).¹² In addition to seeking multispecialty representation, the Commission chose individuals who could bring to the panel the perspectives of physicians paid under different arrangements and from different regions of the country, geographic areas, and practice settings (Table 4).

The meeting was structured to allow focused discussion of each issue first by a subpanel of physicians and later by the full panel. Subpanel assignments were based on both the match between a physician's clinical expertise and the issues to be addressed and the objective of promoting a balanced discussion among subpanel members. Background materials were developed and mailed to panelists prior to the meeting. Finally, a chairperson was selected from among the members of each subpanel, and a Commission staff member served as a resource person to each subpanel.¹³

The full panel met as a group for a working dinner to review its charge and the design of the meeting. The subpanels then met for a full day to work on their issues, summarizing their suggestions at the end of the day for all panel members to review prior to the full panel meeting the following day. The last day of the meeting was devoted to the full panel, discussing and refining the comments and suggestions of each subpanel.

Unlike previous panels run by the Commission, this group was not required to reach consensus but was instructed to fully explore the issues and potential solutions.

Each of the eight broad issues placed on the interspecialty panel's agenda encompassed a set of interrelated issues. This section briefly describes each of those issues, the charge to the panel, and the findings of the panel. The findings of each subpanel are summarized first, followed by a summary of clarifications or new points raised in the full panel discussion.¹⁴

¹² Each of 60 specialty societies was asked to submit four nominations. The panelists were selected from 192 nominees.

¹³ David Helms, Ph.D., of Alpha Center, Washington, DC, helped design the group process used.

¹⁴ Although the subpanels were asked to address the issues as they were developed by the Commission, they were free to discuss related questions outside of their charge. Consequently, several of the subpanel's suggestions addressed additional questions raised within the subpanels, and not all questions were considered.

Table 3. Interspecialty Advisory Subpanels

Panel I Problems Related to Vignettes

Robert A. Berenson, M.D., Chair
 Howard H. Goldman, M.D.
 John F. Helfrick, D.D.S.
 Michael D. Jones, O.D.
 Francis I. Kittredge, Jr., M.D.
 Kenneth A. McKusick, M.D.
 Robert A. Nathan, M.D.
 Thomas G. Olsen, M.D.
 Eugene Sikorski, D.O.
 Rufus F. Stanley, Jr., M.D.

Internal Medicine
 Psychiatry
 Oral/Maxillofacial Surgery
 Optometry
 Neurology
 Nuclear Medicine
 Allergy/Immunology
 Dermatology
 Osteopathic Medicine
 Orthopaedics

Panel II Problems Related to CPT Coding and The Effect of Factors Other than Age on Relative Work

Hiram C. Polk, Jr., M.D., Chair
 Lawrence Blonde, M.D.
 Henry C. Cleveland, M.D.
 Elliott L. Cohen, M.D.
 James G. Hoehn, M.D.
 Derrick L. Latos, M.D.
 Martin E. Liebling, M.D.
 James M. Moorefield, M.D.
 Fred T. Nobrega, M.D.
 Russell Travis, M.D.
 Peter G. Tuteur, M.D.

General Surgery
 Endocrinology
 Trauma Medicine
 Emergency Medicine
 Plastic Surgery
 Nephrology
 Hematology/Oncology
 Radiology
 Preventive Medicine
 Neurosurgery
 Pulmonary Medicine

Panel III Problems Related to Categorization of Invasive Services, Pre and Postservice Work for Nonglobal Procedures, and Assigning Intraservice Work for Surgical Global Services

H. Logan Holtgrewe, M.D., Chair
 James C. Blankenship, M.D.
 James F. Burdick, M.D.
 Robert W. Gillespie, M.D.
 Norman R. Hertzner, M.D.
 Stephen A. Kamenetzky, M.D.
 Sidney Levitsky, M.D.
 Howard W. Meridy, M.D.
 Donald A. O'Kieffe, M.D.
 Paul Raslavicus, M.D.

Urology
 Cardiology
 Transplant Surgery
 Burn Medicine
 Vascular Surgery
 Ophthalmology
 Cardiac and Thoracic Surgery
 Anesthesiology
 Gastroenterology
 Pathology

Panel IV The Pattern of Work for Evaluation and Management Services and The Effect of Age on Relative Work

Meghan B. Gerety, M.D., Chair
 Aina J. Gulya, M.D.
 W. Benson Harer, Jr., M.D.
 Douglas E. Henley, M.D.
 Anthony Hirsch, M.D.
 Timothy T. Kuberski, M.D.
 Myron LaBan, M.D.
 Paul J. Selander, D.P.M.
 Marcus B. Shook, M.D.
 Elizabeth A. Tindall, M.D.
 Paul E. Wallner, D.O.

Geriatrics
 Otolaryngology
 Obstetrics/Gynecology
 Family Practice
 Pediatrics
 Infectious Diseases
 Physical and Rehabilitation Medicine
 Podiatry
 Internal Medicine
 Rheumatology
 Radiation Oncology

Table 4. Demographic Characteristics of the Interspecialty Panel

	Number of Panelists (N=42)
REGION	
Pacific	4
Mountain	3
West North Central	4
East North Central	5
West South Central	5
Middle Atlantic	3
New England	6
East South Central	3
South Atlantic	9
GEOGRAPHIC AREA	
Urban	36
Rural ^a	6
PRACTICE ARRANGEMENT	
Single Specialty	31
Multiple Specialty	11
PRACTICE SIZE	
Solo ^b	6
Group	36
PRACTICE SETTING	
Academic	15
Nonacademic	27
FORM OF COMPENSATION	
Fee-For-Service	21
Salary	13
Combination	8

Notes: ^a Only 10 percent of the 192 nominees practiced in rural areas.

^b Only 15 percent of the 192 nominees were in solo practice.

Problems Related to Categorization of Invasive Services

Currently there is no clear policy specifying how invasive services should be categorized. Consequently, it is not surprising that many of the specialty societies' comments about RWVs reflected concerns about how these services were categorized. For example, RWVs for some procedures were thought to be too low because the society would have categorized it as a surgical global service. RWVs for some surgical global services were thought to be too high because the society would have categorized it as a procedure. These distinctions are important because the Hsiao study defined the pre/post components

differently for surgical global services and nonoperative procedures. Total RWVs for surgical global services in the Hsiao study are intended to reflect the preoperative evaluation (excluding the consultation), scrubbing/waiting, postoperative follow-up on the day of surgery, and 90 days of postoperative hospital and office visits. By contrast, total RWVs for nonoperative procedures in the Hsiao study include little or no pre/post work. For endoscopies, total RWVs include pre- and postservice work performed on the day of the procedure. For other procedures, total RWVs do not include any pre/post work, because physicians are assumed to bill for this separately as a visit.

The Commission asked the interspecialty panel to help it develop guidelines for categorizing invasive services. In its discussion, the panel was asked to consider:

- What criteria should be used to categorize a service as either a non-global procedure, an endoscopy, or a surgical global service?
- What type of process might the Commission recommend for developing a uniform categorization policy?
- How should physicians be educated about the category of service assigned to each CPT code, the components of work included in the payment for each code, and the components of work that should be billed separately?

SUBPANEL COMMENTS:

- *Invasive services should be divided into two classes: surgical global and non-global. Non-global services are those that require only minimal post service care after the day of the procedure and non-incisional endoscopies.¹⁵ Non-global services also include multiple trauma and burn services, post-operative immunosuppressive therapy, chemotherapy, and physical therapy services.¹⁶*
- *The CPT Editorial Board, in collaboration with specialty societies, should recategorize all CPT codes for invasive services as either surgical global or non-*

¹⁵ The panel did not support using the following criteria for categorizing services: incisional/non-incisional, primarily performed by non-surgeons/surgeons, variable pre- and postoperative work, pre- and postservice work that is less than 10 percent of total work, current CPT "starred"/non-starred system, in/outpatient site of service, and morbidity/mortality risk.

¹⁶ Although this was not within the panel's charge, it stated that payments for surgical services should only apply to care directly associated with the surgery. Additional treatment of the disease unrelated to the surgical aftercare should be billed and paid separately. Furthermore, reoperations for complications should be paid separately outside of the global fee.

global. Changes should be noted in the CPT Manual. The Commission should convene a multispecialty panel to adjudicate disagreements concerning the categorization of CPT codes.

- *Both the federal government and specialty societies have roles to play in educating physicians concerning proper categorization and billing procedures for invasive services. This could be accomplished using specialty specific manuals, seminars, and 800-number hotlines. The AMA's proprietary rights to the CPT coding system should not impede the production and distribution of educational materials.*

FULL PANEL COMMENTS:

- *The full panel clarified the subpanel's suggestion by noting that multiple trauma and burn services, post-operative immunosuppressive therapy, chemotherapy and physical therapy services should not be included in the surgical global package.*

Assignment of Pre- and Postservice Work for Non-global Services

Many societies expressed concerns about the way the components of work were defined for nonoperative procedures.¹⁷ With the exception of endoscopies, total RWVs for nonoperative procedures were equal to intraservice RWVs. They were intended to reflect only the work involved in performing the procedure itself because Hsiao assumed that physicians would bill separately for a visit to capture pre- and postservice work related to those procedures.¹⁸ Specialty societies noted that certain pre/post services were always provided in association with a given procedure and that these services might not be appropriate for separate billing as a visit.

In its discussion of this issue, the interspecialty panel was asked to:

¹⁷ The Commission developed a standardized definition for pre/post work components for surgical global services in 1988. Hsiao, in Phase II of his study, intended to capture the components of work as described by this policy. HCFA released a proposed notice in January 1991 that describes a surgical global policy that is quite close to the Commission's policy. Specialty societies have had an opportunity to comment on the HCFA notice. Therefore, this issue was not be considered by the panel.

¹⁸ This assumption was consistent with the guidelines established in the CPT manual, which specified that additional work for nonoperative procedures be billed separately as an office visit (CPT 1990).

- Evaluate two options for paying for the pre/post work associated with procedures -- (a) paying for these services separately as a visit, and (b) including pre/post work in the RWV for each procedure -- in terms of feasibility, equity, potential for abuse, and carrier implementation issues.
- Consider how pre/post work would be calibrated under each option. For example, if pre/post work were paid separately as a visit, which level of service should be used? If pre/post work were included in the RWV for each procedure, what additional research would be required?

SUBPANEL COMMENTS:

- *Once identified, non-global procedures should be assigned total work values by the various specialty societies using a process similar to the one used in the Commission's surgical global service project. In the short run, regardless of the present categorization of these services, total work values assigned by the Hsiao study should be used.¹⁹*

FULL PANEL COMMENTS:

- *All invasive services (global and non-global) have some degree of pre- and postservice work. Patterns of pre- and postservice work to total work for all invasive services need to be studied and then total work can be assigned to the two categories of services.*

Assigning Intraservice Work for Surgical Global Services

The thoracic and vascular surgeons resurveyed their specialties (Noether 1990), in part, because they felt that RWVs assigned in the Hsiao study did not account for pre- and postincisional operating room work (non skin-to-skin intraservice work). The concerns of these specialties also raised the question of whether other surgical specialties might be similarly affected. The Commission looked to the interspecialty panel for guidance in making recommendations about this issue. In particular, the panel was asked to consider the following questions:

¹⁹ The panel rejected the following three options to account for the pre- and postservice work of non-global services: 1) an across-the-board upward adjustment of intraservice work components, 2) adding the RWV for a visit to the non-global intraservice work component, and 3) billing for an office visit in addition to the non-global procedure.

- Does the principal surgeon or another member of the operating team typically perform pre- and postincisional operating room work?
- Was the pre- and postincisional operating work included in estimates of intraservice work in the Hsiao study?
- If not, what criteria could specialty societies and analysts use to identify operations whose RWVs need to be adjusted to account for pre- and postincisional work and how should pre- and postincisional work be calibrated for these operations? What role should data from the Abt thoracic/vascular surgery study play?

SUBPANEL COMMENTS:

- *The intraservice work questions in the Hsiao study are ambiguous, possibly resulting in inaccurate estimates of time and work for the various subcomponents of intraservice work for surgical global services. Furthermore, the Hsiao survey methods do not incorporate adequate screening of respondents with regard to fitness-to-rate.*
- *The principal surgeon performs pre- and postincisional work in the vast majority of cases. When care is provided by others, such as anesthesiologists and cardiologists, it should be paid separately from the surgeon's fee.*
- *The results of the Abt study suggest that the Hsiao study did not accurately measure intraservice work for cardiovascular and thoracic surgeons. Similar inaccuracies may also exist in the intraservice RWVs for other specialties' surgical services.*
- *In the short-term, adjustments to the intraservice RWVs for all surgical global services can be made using available data.²⁰*
- *Long-term solutions for correcting the intraservice component of RWVs will require a total review of surgical RWVs for all specialties.*

²⁰ The available data referred to are the Hsiao study and the Abt study. The Abt pre- and postincisional intensities (work per unit of time) did not appear reasonable to the panelists because they were greater than skin-to-skin intensities.

FULL PANEL COMMENTS:

- *Changes made to the scale of relative work as a result of resurveys should be made after the completion of the cross-linking process, should be budget neutral within the specialty, and should use frequency data.*
- *If data from the Abt study are used to adjust intraservice RWVs, the pre- and postincisional intensities would have to be reduced to values less than the corresponding intraoperative skin-to-skin intensities.*
- *The costs and incentives for specialties to resurvey themselves is a concern. Alternative, more cost-effective processes should be developed to review the scale of relative work.*
- *A problem with compression of some specialty-specific scales of relative work may exist that leads to less complex services being relatively overvalued compared to more complex services. These inequities could create disincentives for tertiary care facilities to provide complex surgical care.*

The Effect of Patient Age on Relative Work

The issue of patient age and its effect on physician work was raised in specialty society comments, but due to time constraints was not discussed at the meeting. Nonetheless, for the sake of completeness, the issue is described below.

In the Hsiao study, each RWV is intended to reflect the relative amount of work involved in providing a service to the typical patient who receives it in the general population. However, if the work relationship among services differs according to patient age RWVs from the Hsiao study may not accurately reflect the work involved in providing services to more selective populations (for example, to Medicare or pediatric patients).

As part of its work on the Medicare Fee Schedule, the Commission has looked at the effect of age on the work involved in providing various types of services (PPRC 1991). For some services, such as the interpretation of laboratory or imaging studies, work probably does not vary substantially according to the patient's age. For services such as visits and consultations, changes in coding could be used to assure equitable payment. For other types of services, however, both the Commission's analysis and comments from specialty societies suggest that there may be a need for age adjusters. For example, adjusters might be needed for surgical global services or nonoperative procedures in which the typical patient is neither a Medicare nor pediatric patient, substantially more work is required to provide the service to a Medicare or pediatric patient, and the CPT code for the service does not vary according to the patient's age.

Under the Medicare Fee Schedule, a Medicare adjuster could be developed that would modify the RWV for certain services by a fixed percentage. This would tailor the Hsiao study scale of relative work so that it applies to the care of typical Medicare patients. To help the Commission make recommendations for the Medicare Fee Schedule, the interspecialty panel was asked to consider:

- What criteria could specialty societies or analysts use to identify codes that should be subject to a Medicare adjuster?
- How should a Medicare adjuster be calibrated?
- How should differences in work for pediatric patients be accommodated under the Medicare Fee Schedule?
- If the Hsiao study scale of relative work were adopted by private payers or Medicare programs, would adjusters, modifiers, or coding changes be needed to make payment equitable? If so, how should they be developed?

The Effect of Factors Other than Age on Relative Work

Societies noted that patient factors such as severity of illness, comorbidity, emergent/urgent/elective nature of the condition, the risk of complications, body site, or size of the patient can substantially affect the amount of work required to deliver a service. Societies also noted systematic differences across specialties (or across physicians within a specialty) with regard to factors such as site of service (ER/inpatient/office), time of service (day/night), or treating referred patients. Societies believed these factors caused their specialty's average work to be higher than that of other specialties performing the same service.

If one or more of these factors significantly affect the work of a service, and physicians systematically differ in their patient mix with respect to these factors, the problem could be addressed by use of a coding modifier that will affect payment. To help determine whether this problem exists and how to address it, the panel was asked to discuss the following questions:

- What factors (other than patient age) affect the work in performing a service, and for what services do these apply?
- When are the resulting differences in work among physicians and specialties large enough to warrant the use of a modifier, and how can the existence and extent of the differences be determined?

- How can a modifier (which would result in a uniform increase in payment across services to which it is applied) be defined and calibrated?
- What are the potential problems in implementing the use of such a modifier (for example, it might not be recognized by carriers for payment)?

SUBPANEL COMMENTS:

- *A payment modifier to account for differences in work should meet the following criteria: 1) it captures substantial and systematic differences in work; 2) it can be calibrated; and 3) its use is verifiable and not easily subject to gaming.*
- *Three modifiers meet the criteria and should be developed for use: 1) a modifier for operative risk²¹ (use of the American Society of Anesthesiology's classification of operative risk was recommended²²); 2) a modifier for recurrent or persistent conditions (this modifier should apply only to procedures and surgical services for which physician work increases due to the presence of a recurrent or persistent condition²³), and 3) a modifier for services delivered between midnight and 6:00 am.²⁴*
- *Other factors that have an effect on work but do not easily lend themselves to the stated criteria include demanding patients, requirements of third-party payers and HMOs, procedures performed under local versus general anesthesia, and site of service (specifically, emergency departments). Communication barriers and disabilities increase work, however, specific recommendations were not made for modifying payment to account for them.*

²¹ Payment within a surgical code should be adjusted when the modifier is adopted so that total payments for the service are budget neutral.

²² The ASA classification of operative risk measures severity of illness, coexisting illnesses, and urgency of the operation. This classification is a validated scale that predicts the risk of dying.

²³ The subpanel felt that a modifier for recurrent or persistent conditions should not be applicable to "scopies" because the work involved is not affected. Furthermore, they felt that the modifier should not usually pertain to reoperations that occur within the 90-day surgical global period.

²⁴ This modifier should be calibrated by survey data that documents differences in work.

FULL PANEL COMMENTS:

- *There was some disagreement on whether or not the American Society of Anesthesiology's classification of operative risk adequately captures variation in severity of illness and co-existing illnesses for all surgical procedures. The panel also discussed the limitations of other instruments that measure severity of illness. Some suggested that work should be done to develop a usable severity-of-illness modifier for EM services.*
- *The panel clarified that a modifier could apply to "scopies" if the recurrent condition increases physician work.²⁵*

Problems Related to Vignettes

Specialty societies identified four closely related issues that underlie problems related to vignettes. They include vignette ambiguity, vignettes that were not representative of the typical service for their assigned CPT codes, vignettes that were assigned to incorrect CPT codes, and vignettes that were not surveyed in the specialty that provides the service most frequently.

Vignette Ambiguity. Vignettes describing clinical scenarios were used in the Hsiao study to capture the average work of a physician providing a service to the typical patient. In their comments, specialty societies suggested that relative work values (RWVs) assigned to some CPT codes were inaccurate because the vignettes describing those codes were ambiguous. They thought physicians in the survey would have interpreted the vignette differently thus biasing the RWV assigned to the vignette.

Unrepresentative Vignettes. Societies also commented that some vignettes described services that were at the high or (more commonly) low range of work for their assigned CPT codes. As a result, they felt that RWVs for those codes did not reflect the mid-range of work.

Vignette/Code Mismatch. Vignettes that societies felt were assigned to the wrong CPT code are an extreme example of unrepresentative vignettes.

Vignettes Surveyed in a "Low-Frequency" Specialty. Some societies noted that they should not have been surveyed for a given code because their specialties provide the service

²⁵ An example of a condition that increases physician work during "scopies" is recurrent laryngeal papillomatosis. The recurrence of these papillomas and the scarring that occurs from prior removal of lesions makes visualization of, obtaining access to, and removing the lesion increasingly difficult with subsequent laryngoscopies.

infrequently. Other societies commented about codes that were not included in their specialty's survey despite their specialty providing the service frequently.

Problems with vignettes do not necessarily lead to inaccurate RWVs. For example, physicians may have had different interpretations of an ambiguous vignette, but the geometric mean of their estimates may still reflect the average work involved in that code. In this case, the ambiguity would have introduced error but not bias into the estimate of work. RWVs for vignettes surveyed in a "low- frequency" specialty may still be accurate if the vignette represents the typical service associated with that code for all specialties that use it.

In discussing these issues, the interspecialty panel was asked to consider the following questions:

- What criteria could specialty societies or analysts use to identify vignette problems that resulted in inaccurate RWVs (i.e. vignette problems that introduced bias as well as measurement error into the estimate of work for a given code)?
- What sources of data could be used to correct RWVs for these codes (for example, OR time data from a representative sample of hospitals)?
- If vignettes are used to revise and update the scale of relative work, what criteria should be used to develop these vignettes? This discussion could focus on characteristics of vignettes, assigning codes to vignettes, and making decisions about the specialties that should be surveyed about vignettes.
- What are the implications of using CPT code descriptors rather than vignettes to revise and make up the scale of relative work? What criteria would code descriptors have to meet to make them suitable for magnitude estimation? If estimates of work for a given code descriptor vary across physicians, what types of analysis (for example, identification of bimodal distributions) would be needed to differentiate measurement error from the provision of different services?
- What criteria could be used to identify codes that were not surveyed in appropriate specialties (for example, using BMAD frequency data)?

SUBPANEL COMMENTS:

- *To assure confidence in a magnitude estimation process to determine RWVs, the value for the standard must be established as a reliable and valid measure of the mid-range of work for the service.*
- *Omission of service descriptors may result in ambiguous vignettes or vignettes that do not describe the mid-range of work. These descriptors include: patient age, gender, comorbidities, preservice diagnosis or condition, precise description of the service, postservice diagnosis, and location of the service.²⁶*
- *Some CPT code descriptions are narrowly defined and specific enough in detail to substitute for vignettes in the estimation of relative work.*
- *An inaccurate RWV caused by a poorly described service or the inappropriate selection of specialties to survey on a given vignette should be corrected by HCFA, wherever possible, on empirical grounds.²⁷ However, reliable data to assist with this task may be unavailable in many cases.*
- *HCFA should implement a process for revising current RWVs that is timely and responsive to specialty societies' identification of problems with the Hsiao study results. When available data is not conclusive, single or multispecialty panels could be used to negotiate the revision of RWVs. Specialties that frequently provide the service in dispute should be involved in the negotiation process.²⁸ Such a process would require impartial third-party oversight to assure fair consideration of disputes and avoid gaming.²⁹*

²⁶ These same content descriptors would be useful in the development and evaluation of clinical descriptions and CPT codes used in a future update process.

²⁷ The specialty claiming that a RWV is biased should seek objective data (for example, service time and charges) as proxies for work to compare with Hsiao's data.

²⁸ The negotiation process and revision of RWVs should be sensitive to the relative frequency each specialty provides the service in question.

²⁹ Conducting these negotiations in a budget-neutral fashion by specialty is one mechanism to prevent gaming.

- *For future updates of RWVs a process involving several independent groups of physicians could be used to estimate RWVs. This process would require strict third-party oversight.³⁰*
- *An update of RWVs should include periodic review of newly established codes, particularly for new technologies. All RWVs should be reviewed and revised to reflect real changes in the amount of physician time and work required to provide the service and in the frequency that various specialties provide it.*

FULL PANEL COMMENTS:

- *There was disagreement on whether or not service descriptors containing final diagnoses would bias the respondent who is estimating work.*
- *CPT codes that encompass a broad range of work do not lend themselves to the accurate estimation of the mid-range of work. Furthermore, they contribute to inaccurate billing practices. Such codes should be split.*
- *There may be categories of services (for example, imaging services) that only require a description of the procedure itself because variation in patient characteristics and diagnosis does not substantially affect the amount of work required to provide the service.*
- *Current RWVs that are accurate could adequately serve as "standards" in an update process to determine values for new services.*

Problems Related to CPT Coding

Under the customary, prevailing, and reasonable (CPR) payment method, payment for a given service varies by locality and the physician's specialty. Therefore, if physicians in different specialties or different parts of the country use the same code to bill for different services, the allowed charge can vary (theoretically at least) to reflect these differences. But under the Medicare Fee Schedule, payment will not vary to accommodate differences

³⁰ The process discussed by the subpanel would involve dividing physicians from relevant specialties into three independent groups. Group one would write clinical scenarios spanning the full range of work for the code. Group two would estimate the RWV for each scenario based on existing RWVs for similar services. Group three would assign CPT codes to each scenario. The oversight committee would determine the relative frequency in which each scenario occurs in actual practice and calculate a weighted average accordingly. The RWVs determined by group two but improperly assigned by group three to the original CPT code would be excluded from the calculation of an updated RWV. During the full panel it was suggested that independent groups could each complete the whole process and an impartial oversight committee could compare the results.

in the use of codes. A single value will be assigned to each code nationally and this value will apply to physicians in all specialties. Consequently, a given code must represent a similar amount of work to all physicians who use it if payment is to be equitable.

Comments by specialty societies suggested that a number of CPT codes represent a range of services entailing substantially different amounts of work. This would not be a problem if all physicians who use these codes provided the same mix of services. But the specialty societies noted that this is frequently not the case. Some physicians bill only for services that at either the low or high end of the range of work when they use these codes. Since RWVs are assigned to codes, a resource-based payment method, like the Medicare Fee Schedule, places new demands on the coding system. To help the Commission, professional societies, HCFA, and the Congress address problems involving CPT codes, the panel was asked to discuss the following questions:

- What are the goals of a coding system that undergirds a national, resource-based fee schedule without specialty differentials? What criteria should codes in such a system satisfy?
- What criteria could be used to identify current CPT codes that would be likely to result in inequitable payment under the Medicare Fee Schedule?
- When should codes be revised or split? What criteria should apply to this decision? What are the drawbacks to splitting codes?
- What are the parameters that should guide the development of new codes to optimize their use in the resource-based Medicare Fee Schedule?

SUBPANEL COMMENTS:

- *The panel endorsed the following goals of a coding system to be used in a national, resource-based fee schedule. Such a coding system should: 1) be clear and applied uniformly by physicians and carriers;³¹ 2) comprise clinically meaningful and clearly differentiated codes;³² 3) be as simple and efficient to*

³¹ Medicare carriers' payment policies must be uniform. This is critical to the success of the fee schedule and a prerequisite to the recommendations of the panel.

³² Descriptors for procedural codes should distinguish clearly between the procedure and EM services which should be separately billable. Descriptors for procedural services should not incorporate time so that efficiency is not penalized. Specialty societies should help develop the descriptors.

use as possible; 4) facilitate the accurate assignment of resource-based relative values; 5) encourage efficient and appropriate delivery of services; 6) facilitate the appropriate use of codes and allow payers to detect their inappropriate use;³³ and 7) enable the generation of accurate data about the services provided.

- *HCFA should develop processes for future updating and revision of RWVs and codes that accomplish the above goals and involve extensive input from physicians who practice clinical medicine.*
- *The frequency with which codes and services are used in relation to ICD-9 diagnosis codes should be monitored to detect substantial changes or shifts in their use. Codes that should be periodically resurveyed to update their RWVs include codes that demonstrate a bimodal distribution of work, codes surveyed using CPT code descriptors, and codes suggested by specialty societies as problematic. New codes for new technologies, new uses of existing technology, and services to treat new illnesses should be considered after the effectiveness of new services has been established and confirmed. Payment for these new codes could be limited to specific diagnoses.*
- *Codes should be consolidated when they represent services with similar work value and are used to treat the same condition. When individual codes represent a broad range of work or differently valued therapies for the same condition they may need to be split. However, an important drawback to splitting codes is the potential for unbundling. Finally, when new services replace existing ones, both codes should coexist for some time before the older code is eliminated.³⁴*

FULL PANEL COMMENTS:

- *HCFA should develop a clear policy for how coding decisions should be made to further these goals. This policy should be developed with input from all affected parties, especially practicing physicians. The policy should be incorporated into HCFA's contracts with the CPT Editorial Panel.*

³³ The panel was particularly concerned with guarding against unbundling.

³⁴ New uses of existing technology should qualify for new codes only when the work value of the new use is substantially different from the existing code.

- *The full panel clarified that new codes should be established for all new technologies to help monitor their use, even if payment is not permitted or different from the replaced services.*
- *The needs for data on utilization should be considered when deciding to consolidate codes.*

The Assignment of RWVS to Evaluation and Management Services

As part of its refinement process, the Commission used data from the Visit Survey to assess how well RWVs assigned to visits of different durations and different types in Phase II of the Hsiao study reflect the pattern of work in actual practice. Substantial differences between the two studies suggest that Phase II RWVs may need to be refined before the Medicare Fee Schedule is implemented. For example, compared to the Visit Survey, Phase II RWVs appear to understate the value of shorter visits, overstate the value of longer visits, and do not reflect differences in effort (work per unit of time) between different types of visits. Since physicians in different specialties do not provide the same mix of visits (for example, some provide primarily short established patient office visits, whereas others provide a greater proportion of consultations or longer visits), distortions in RWVs could result in inequitable payment.

The Commission looked to the interspecialty advisory panel for guidance in developing recommendations for refining RWVs for EM services. In particular, the panel was asked to consider how the Hsiao study RWVs for visits could be refined so that the pattern of work for EM services:

- has face validity (i.e., accurately reflects differences in fixed work and effort between shorter and longer visits and between different types of visits);
- does not create incentives for "upcoding", inefficiency, or the provision of unnecessary EM services, and
- does not compromise access to care for patients with multiple or complex problems or create incentives for physicians to spend too little time with such patients.

SUBPANEL COMMENTS:

*The above conditions can be met by implementing a payment system that incorporates the following elements:*³⁵

- *a pattern of relative work that recognizes differences in effort (work per unit of encounter time) across different classes of visits, e.g., new versus established patient visits, initial versus subsequent visits, and consultative versus non-consultative visits;*³⁶
- *a modifier that would increase payment for each visit code by a fixed percentage for visits with patients who have communication barriers, disabling cognitive or physical impairment, or an unusual need for counseling or coordination of care;*³⁷
- *a pattern of relative work in which the total work per unit of encounter time decreases as visits become longer, but less severely than in the Visit Survey.*³⁸

FULL PANEL COMMENTS:

- *Several panelists again raised concerns expressed in the subpanel about the assumptions that either the linear pattern of relative work for EM services in*

³⁵ The subpanel felt that the linear pattern of relative work for EM services in the Hsiao study undervalues shorter visits, which could reduce access to care for patients who primarily require shorter visits (family practice and pediatric patients) and reduce the attractiveness of these specialties to physicians in training. On the other hand, the subpanel felt that the curvilinear pattern of relative work for EM services in the Visit Survey appears to undervalue longer visits. This could reduce access to care for patients who require lengthy complex visits (geriatric medicine, rheumatology, physical medicine, infectious disease and neurology patients) and reduce attractiveness of these specialties to physicians in training.

³⁶ This would make payment more equitable for physicians such as rheumatologists and infectious disease specialists, who provide proportionally more consultations and new patient visits.

³⁷ Such a modifier would make payment more equitable for physicians who care for these patients, such as geriatricians, psychiatrists, rheumatologists, and oncologists.

³⁸ The subpanel noted that the shape of the curve defining the relationship between encounter time and total work may have serious impact on the process of care, quality of care, and health care utilization. The linear relationship in Phase II of the Hsiao Study, in which total work per unit of encounter time is independent of visit duration, might encourage appropriate care for complex patients. However, it could also create incentives for inefficiency and inappropriate health care utilization, e.g., upcoding and the provision of more extensive EM services than medically necessary. This could be a particular problem in areas where physician supply is greater than demand. The curvilinear relationship in the Visit Survey, in which total work per unit of encounter time decreases as visits become longer, might encourage more efficient patient care. However, it could also create incentives for shorter visits than are medically necessary, fragmented patient care, and increased diagnostic testing and referrals.

the Hsiao study or the curvilinear pattern in the Visit Survey were correct. They either disagreed with or called for further consideration of the pattern of relative work proposed by the subpanel.

OTHER ISSUES ADDRESSED BY SPECIALTY SOCIETIES

Specialty societies' comments about other important issues, such as determining the appropriate method to link the Radiologists' Fee Schedule to the Hsiao common scale and problems related to technical aspects of the cross-linking methodology, were reviewed and analyzed by Commission staff but were not referred to the interspecialty panel. Many of the issues raised by specialty societies in these areas are reflected in the Commission's response to the NPRM (PPRC 1991c).

Radiology RWVs

All specialty societies that participated in the Commission's evaluation and refinement process were asked to comment on various aspects of radiology RWVs. Societies representing specialties that were surveyed in the Hsiao study for radiology services were explicitly asked to comment on the Hsiao RWVs for radiology services.³⁹ Additionally, all societies, including those representing specialties not directly surveyed for radiology services, were asked to compare rescaled RFS values to the Hsiao RWVs and comment on the Commission's proposed method for rescaling RFS values.

The comments about radiology work values appeared to vary according to the proportion of radiology services in a specialty's service mix. Societies that represent the radiology specialties generally favored the RFS values while non-radiology societies endorsed the Hsiao RWVs.⁴⁰ The primary objections of non-radiology societies to RFS values concerned the exclusion of certain providers of radiology services from the process used to develop RFS values and the perception that the methods for estimating RFS and Hsiao

³⁹ These specialties included nine non-radiology specialties (dermatology, neurology, obstetrics and gynecology, ophthalmology, oral and maxillofacial surgery, orthopaedic surgery, psychiatry, pulmonary medicine, and rheumatology) and three radiology specialties (diagnostic radiology, radiation oncology and nuclear medicine).

⁴⁰ Societies that represented specialties not surveyed by Hsiao for radiology services but commented during the refinement process included: cardiology, cardiothoracic surgery, family practice, infectious disease, internal medicine, nephrology, pediatrics, transplant medicine, and urology.

values were not comparable.⁴¹ Societies representing radiology specialties disputed the vast majority of Hsiao RWVs in favor of RFS values for their surveyed services.⁴²

Only a few societies specifically commented on the Commission's proposed method to calculate an imaging rescaling factor.⁴³ The Commission calculated an imaging rescaling factor by weighting each ratio of Hsiao RWVs to RFS values for a common set of services using 1988 BMAD allowed charges. While some societies indicated that this weighting method appeared reasonable, others objected strongly. Those who objected were primarily concerned about using historical charge data to weight the ratios. These societies explained that there has been significant change in the charge and volume of different radiology services between 1988 and 1990. They reasoned that historical allowed charges, as a basis for weighting ratios, misrepresents current service mix and allowed charges.⁴⁴

Cross-Specialty Linkages

All comments submitted by specialty societies about specific cross-specialty linkages and the overall strength of the specialty's linkage to the common scale were carefully reviewed. Approximately 20 percent of all links were disputed. In general, specialty societies were more satisfied with links that involved the same rather than different services. For only two links did both societies involved dispute the link and agree on the direction of the error. Because it is difficult to establish with certainty that linked services do not involve similar or comparable work, the Commission did not recommend that individual cross-specialty linkages be removed.

⁴¹ The RFS is a relative value scale for radiology services that was developed by the American College of Radiology (ACR). The ACR conducted surveys of radiologists and radiological facilities to determine the historical charges and the relative complexity of a sample of radiology services. (To rate relative complexity, physicians were asked to consider the combination of technical skill and physical effort, mental effort and judgement, quality control and quality assurance, and concern about relative harm to the patient.) This information was used to determine preliminary values. The ACR used a consensus process to refine these values and extrapolate values for non-surveyed services. The consensus process included members of all radiology subspecialties. Both the technical and professional component of RFS values are recognized by HCFA for payment purposes except for the technical component of interventional radiology procedures.

⁴² Societies representing diagnostic radiology and radiation oncology disputed all Hsiao radiology RWVs. The societies representing nuclear medicine raised concerns about the accuracy of both the Hsiao and RFS values. Although they endorsed the RFS in general, they disputed RFS values for some nuclear medicine services.

⁴³ Under the Omnibus Budget Reconciliation Act of 1989, HCFA is required to modify RFS values to assure that they are comparable to the RWVs established for similar services in the Medicare Fee Schedule. The Commission proposed an imaging rescaling factor that could be used to adjust the professional component of each RFS value.

⁴⁴ In the NPRM for the Medicare Fee Schedule, HCFA proposed an imaging conversion factor that uses an unweighted average ratio of Hsiao RWVs to RFS values for a common set of services. The Commission stated in its comments on the NPRM that this is a reasonable approach.

In addition, several specialty societies with few links indicated that their specialty was tenuously linked to the common scale. The Commission does recognize that some specialties may be weakly linked.⁴⁵ Both the Commission and the Hsiao team agree that specialties with too few links may be poorly linked.⁴⁶ Adding additional links for these specialties may raise or lower a specialty's overall position on the common scale. Nonetheless, adding links is the best way of providing confidence that they are aligned correctly on the common scale.⁴⁷

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⁴⁵ In its 1991 Annual Report to the Congress, the Commission identified preliminarily specialties that may be weakly linked based on meeting three of six criteria including: high standard error of alignment, few links, few specialties to which it is linked, a high proportion of links that differ substantially in terms of work, and a high proportion of linking vignettes with low response rates. The identified specialties were: nuclear medicine, pathology, radiation oncology, anesthesia, emergency medicine, and oral and maxillofacial surgery.

⁴⁶ The Hsiao team indicated that the number of links is an important criterion for identifying specialties meriting further study. The specialties they identified as requiring further study are those with fewer than eight links. These specialties include pathology, nuclear medicine, oral and maxillofacial surgery, radiation oncology, allergy and immunology, anesthesia, and infectious disease (Hsiao 1991).

⁴⁷ The Commission previously stated that weighting of cross-specialty links was an improvement in Phase II methods. The society representing pathology (one of the specialties identified as having too few links) contracted with Abt Associates Inc. to study the effect of weighing links on pathology's alignment to the common scale. This analysis indicated that significant differences in alignment on the common scale occurred for pathology, radiation oncology, and nuclear medicine when biweighting was not used. It would be inappropriate to weight the links for some specialties and not others, and there is no *a priori* reason for not using biweighting. The Abt analysis demonstrates, however, that the alignment on the common scale of specialties with few links can be sensitive to the linking methodology used.

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APPENDIX A

COMMISSION RECOMMENDATIONS FOR REFINING THE SCALE OF RELATIVE WORK

Appendix A. Commission Recommendations for Refining the Scale of Relative Work

RECOMMENDATIONS FOR INVASIVE SERVICES

- HCFA, with input from all affected parties, should develop a clear policy for categorizing invasive services as either surgical global services or nonglobal procedures. Special payment policies should be developed for exceptional types of surgery (such as transplant, multiple trauma, and burn surgery).
- Relative work values (RWVs) for surgical global services should be refined to: (1) account for the substantial pre- and postincisional operating room work involved in certain operations; and (2) correct estimates of pre/post time and intensity for perioperative visits.
- Surgical services related to complications should be paid separately from the surgical global fee. If these services are included in the surgical global service (as HCFA proposed in the NPRM), equitable payment will require the development of a surgical complications modifier.
- RWVs for nonglobal procedures other than endoscopies should be revised to account for pre/post work directly related to the procedure.
- Since visits provided in the 30-day period following a procedure are usually related to management of the underlying condition rather than to the procedure itself, the timeframe in HCFA's proposed payment policy for nonglobal procedures should be substantially shorter than 30 days.
- Physicians and carriers should be provided with: (1) a list of the CPT codes that will be paid as surgical global services and as nonglobal procedures; (2) the component services that are included in the payment for surgical global services and nonglobal procedures; and (3) the services that can be billed in addition to surgical global services and nonglobal procedures.

RECOMMENDATIONS FOR EVALUATION AND MANAGEMENT (EM) SERVICES*

- The pattern of work for EM services should be revised so that total work per unit of encounter time decreases to a limited extent as visits become longer.
 - The pattern of work across classes of visits should be revised so that total work per unit of encounter time is greater for new patient visits than established patient visits, for initial visits than subsequent visits, and for consultations than for nonconsultative visits.
 - EM payment should be increased by a fixed percentage (through a special modifier) for visits with patients who have communication barriers, disabling cognitive or physical impairment, or an unusual need for counseling or coordination of care.
 - The visit coding system proposed in the NPRM should be revised so that it will not send mixed messages to physicians. This can be accomplished by simplifying the system and by making time and content congruent for each level of service.
-

RECOMMENDATIONS TO TAILOR THE SCALE OF RELATIVE WORK TO THE MEDICARE POPULATION

- A Medicare adjuster should be developed that would modify the RWV for the service to which it is applied by a fixed percentage.
- The adjuster should be applied to services in which: (1) the typical patient is not a Medicare patient; and (2) substantially more work is required to provide the service to a Medicare patient than to the typical patient.

RECOMMENDATIONS TO CORRECT PROBLEMS SPECIFIC TO INDIVIDUAL SERVICES

- Vignette and fitness-to-rate problems should be corrected, wherever possible, on empirical grounds.
- Suspected vignette and fitness-to-rate problems that cannot be substantiated or corrected with data from the Hsiao study should be refined through the use of multispecialty or specialty-specific panels.

RECOMMENDATIONS FOR REFINING CPT CODES

- CPT codes that are ambiguous or that encompass a broad range of services entailing substantially different amounts of work should be revised to provide a sound basis for equitable payment.
- To ensure that refinements in the coding system meet the needs of the new payment system, HCFA should establish clear policy goals that will provide a framework for consistent coding decisions.

Note: ^a The three recommendations for revising RWVs for EM services are presented as a package and are not intended to stand alone.

APPENDIX B

**SPECIALTY SOCIETIES INVITED
TO PARTICIPATE IN THE
REFINEMENT PROCESS**

Appendix B. Specialty Societies Invited to Participate in the Refinement Process

Surveyed Specialties

Allergy/Immunology	American Academy of Otolaryngic Allergy
Anesthesia	American College of Allergy & Immunology
Cardiac and Thoracic Surgery	American Society of Anesthesiologists
	American Association for Thoracic Surgery
	Society of Thoracic Surgeons
Cardiology	American College of Cardiology
Dermatology	American Academy of Dermatology
Emergency Medicine	American College of Emergency Physicians
Family Practice	American Academy of Family Physicians
Gastroenterology	American College of Gastroenterology
	American Gastroenterological Association
	American Society for Gastrointestinal Endoscopy
General Surgery	American College of Surgeons
	American Society of Abdominal Surgeons
	American Society of Colon and Rectal Surgeons
Hematology/Oncology	American Society of Clinical Oncology
	American Society of Hematology
Infectious Disease	Infectious Diseases Society of America
Internal Medicine	American College of Physicians
	American Society of Internal Medicine
Nephrology	Renal Physicians Association
Neurology	American Academy of Neurology
Neurosurgery	American Association of Neurological Surgery
	Congress of Neurological Surgeons
Nuclear Medicine	American College of Nuclear Physicians
	American Society of Nuclear Medicine
Obstetrics/Gynecology	American College of Obstetrics/Gynecology
Ophthalmology	American Academy of Ophthalmology
	American Society of Cataract and Refractive Surgery
Oral/Maxillofacial Surgery	American Association of Oral Maxillofacial Surgery
Orthopaedics	American Academy of Orthopaedic Surgeons
Osteopathic Medicine	American Osteopathic Association
	American Osteopathic College of Radiology
Otolaryngology	American Academy of Otolaryngology
Pathology	American Society of Clinical Pathologists
	College of American Pathologists
Pediatrics	American Academy of Pediatrics
Physical and Rehabilitative Medicine	American Academy of Physical Medicine and Rehabilitation
Plastic Surgery	American Association of Plastic Surgeons
	American Society of Plastic and Reconstructive Surgery
Psychiatry	American Psychiatric Association
	American Society of Addiction Medicine
Pulmonary	American College of Chest Physicians
	American Thoracic Society
Radiation Oncology	American Society for Therapeutic Radiology and Oncology
Radiology	American College of Radiology
Rheumatology	American College of Rheumatology
Urology	American Association of Clinical Urologists
	American Urological Association
Vascular Surgery	Society for Vascular Surgery

Limited License Practitioners

Optometry	American Optometric Association
Podiatry	American College of Foot Surgeons
	American Podiatric Medical Association

Unsurveyed Specialties

Burn Medicine	American Burn Association
Endocrinology	Endocrine Society
Geriatrics	American Geriatrics Society
Preventive Medicine	American College of Preventive Medicine
Transplant Medicine	American Society of Transplant Physicians
	American Society of Transplant Surgeons
Trauma Medicine	American Trauma Society

APPENDIX C

MATERIALS MAILED TO SPECIALTY SOCIETIES TO REVIEW NON-RADIOLOGY RWVs AND CROSS-SPECIALTY LINKAGES

INSTRUCTIONS

The first part of the refinement process will provide your society with an opportunity to review and comment on two aspects of the scale of relative work: (1) relative work values (RWVs) for surveyed services; and (2) cross-specialty links. Please read these instructions carefully before you begin. If you have any questions, feel free to call Vicky Pebsworth at (202) 653-7220.

I. RWVs FOR SURVEYED SERVICES

In this mailout, we are enclosing a list of RWVs for all of the services in your specialty (other than EM, imaging, and anesthesia services) that were surveyed directly in the Hsiao study.¹ Each service is identified by its descriptive vignette, the identifier letter assigned to it in the Hsiao study, the CPT code to which it was assigned, and the phase of the Hsiao study in which it was surveyed.

The RWVs for your specialty's surveyed services are those assigned in the final report of Phase II of the Hsiao study (see Table 12.2).² For some services, Hsiao and his colleagues assigned intraservice work, pre/postservice work, and total work values. For other services, they assigned only total work values. We have provided different response forms for you to use in commenting on RWVs, depending on how they were assigned by Hsiao. The correct response form to use for each service is indicated in the right-hand column on your list of RWVs.

Response Form A: Intraservice and Pre/Postservice Work. For nonoperative services that were assigned intraservice work, pre/postservice work, and total work values, use Response Form A to comment on intraservice work and pre/postservice work.³

Response Form B: Operations. For operations, we are only asking for comments about intraservice work at this time.⁴ Use Response Form B for operations.

Response Form C: Total Work. For services that were assigned only total work values, use Response Form C to comment on total work.

¹ RWVs for EM services are not included in this step of the refinement process because codes for visits and consultations are not uniformly interpreted by physicians and are currently being revised. RWVs for imaging services will be refined in a later step of the process. Societies will not be reviewing Hsiao RWVs for anesthesia services because MFS payment for these services will be based on the Anesthesia Uniform Relative Value Guide.

² This table contains values for services surveyed in both Phases I and II.

³ Since intraservice work + pre/postservice work = total work, you need not comment on total work for these services.

⁴ Operations are billed as surgical global services. As we discussed in the accompanying letter, specialty societies will have an opportunity to review and comment about methods for assigning pre/postservice work values to operations in March, when the Commission's surgical global service project is completed.

You only need to fill out RWV RESPONSE FORMS for services with RWVs that you consider to be inaccurate. Please be sure to identify your society, the specialty you represent, and the service in question (by code and vignette) for each form you fill out. In the space provided, indicate what you believe would be a more accurate estimate of relative work for the service and then write a concise discussion of the underlying problem, attaching any supporting data that substantiate your claim.

Try to be specific about any problems you identify. For example, let us know if your concern relates to the clarity of a vignette, the CPT code assigned to a vignette, whether a vignette represents the typical service for its CPT code, the range of work encompassed by a vignette's CPT code, characteristics of the physicians who responded to questions about a vignette, the definitions of the intra, pre/post, and total components of a service, questions physicians were asked about work and time, variance in physicians' responses, the method used to impute values for pre/post work or total work, etc. Different problems will, of course, require different types of supporting documentation. In some cases, discussions drawing on clinical expertise will be most appropriate. In others, we will expect a more analytic discussion based on the Hsiao study results and data from other reliable sources.

If you wish to provide the Commission with general comments that apply to more than one vignette, please feel free to do so. These comments may relate to methodological issues (such as the methods used to impute pre/post work for certain categories of services), coding issues, your specialty's reference service, or the spectrum of services represented by your specialty's vignettes.

II. CROSS-SPECIALTY LINKS

In this mailout, we are also enclosing a list of the vignettes that the Hsiao study uses to link your specialty's scale of relative work to others. This list is drawn from Appendix H.1 in the final report of Phase II of the Hsiao study. Each link is identified by its link identifier number, the specialties sharing the link, the survey vignette in each specialty, and the phase of the Hsiao study in which each specialty's vignette was surveyed. The Hsiao researchers based links on different criteria. Some are based on the work involved in the intraservice portion of the vignettes. These are indicated by "I" in the "Type of Link" column. Others are based on total service work. These are indicated by "T". Still other links are based on work per unit time. These are indicated by "W".

You only need to fill out CROSS-SPECIALTY LINK RESPONSE FORMS for links that you consider to be weak or invalid. Please be sure to identify your society, the specialty you represent, and the link in question (by link identifier number, the specialties sharing the link, and the vignette used for each specialty). Please note whether the link is based on intraservice work, total work, or work per unit time by checking the appropriate box. Then indicate whether you believe the link to be weak or invalid by checking the appropriate box. Finally, in the space provided, write a concise discussion of why you think the linking vignettes do not represent the same or equivalent service. Attach any supporting data that substantiate your claim.

Once again, try to be specific about any problems you identify. For example, let us know if your concern relates to the criterion (intraservice work, total work, or work per unit time) on which the link is based, clinical differences across specialties in the diagnosis and treatment of the patient in a common vignette, differences across specialties in the time spent delivering the services in same or equivalent vignettes, differences in the way questions about time and work were asked in Phases I and II of the Hsiao study, etc. Supporting documentation should be appropriate to the problem discussed.

If you wish to provide the Commission with more general comments about your specialty's links or the cross-specialty alignment process, please feel free to do so. Also, if you can identify any other potential links, please do so, indicating specialties that would share the link and the vignettes that would be used for each specialty.

Please provide the Commission with your responses about RWVs and links on a rolling basis. We must receive all comments no later than **February 11, 1991**. We need your responses by this date if we are to have time to analyze them, convene the interspecialty advisory panel, and make recommendations to HCFA and the Congress by the June deadline.

RWV RESPONSE FORM A
INTRASERVICE AND PRE/POSTSERVICE WORK

Specialty Society : _____

Date : _____

Specialty : _____

CPT code : _____ Vignette: _____

By completing this form you are questioning the accuracy of the assigned (check one):

☐

Intraservice work value

☐

Pre and post service work value

☐

Both

You believe a more accurate work value(s) would be:

Intraservice work value : _____ Pre and post service work value : _____

Concisely state what you believe to be the problem(s) with the assigned work value(s) and provide supporting documentation that substantiates your claim. Attach additional pages if necessary.

**RWV RESPONSE FORM B
OPERATIONS**

Specialty Society : _____ Date : _____

Specialty : _____

CPT code : _____ Vignette: _____

By completing this form you are questioning the accuracy of the assigned intraservice work value.

You believe a more accurate intraservice work value would be:

Intraservice work value : _____

Concisely state what you believe to be the problem(s) with the assigned intraservice work value and provide supporting documentation that substantiates your claim. Attach additional pages if necessary.

RWV RESPONSE FORM C
TOTAL WORK

Specialty Society : _____ Date : _____

Specialty : _____

CPT code : _____ Vignette: _____

By completing this form you are questioning the accuracy of the assigned total work value.

You believe a more accurate total work value would be:

Total work value : _____

Concisely state what you believe to be the problem(s) with the assigned total work value and provide supporting documentation that substantiates your claim. Attach additional pages if necessary.

CROSS-SPECIALTY LINK RESPONSE FORM

Specialty Society : _____ Date : _____

Specialty : _____

Link Identifier # : _____ Specialty sharing the link : _____

Your Specialty's Vignette: _____

The Other Specialty's Vignette: _____

This link is based on (check one):

☐

Intraservice work

☐

Total service work

☐

Work per unit time

You believe this link to be (check one):

☐

Weak

☐

Invalid

Concisely state what you believe to be the problem(s) as to why you do not think the linking vignettes do not represent the same or equivalent work and provide supporting documentation that substantiates your claim. Attach additional pages if necessary.

SPECIALTY - GENERAL SURGERY

PHASE	VIGNETTE CODE	CPT-4 MOD	VIGNETTE DESCRIPTION	PRE-POST WORK	INTRA WORK	TOTAL WORK	COMMENT USING RESPONSE FORM:
1	B	32020	Chest tube insertion for spontaneous pneumothorax, in 20 year old.	290.0	102.0	392.0	A
1	I	45300	Rigid sigmoidoscopy, without biopsy, in office.	50.0	57.0	115.0	A
1	J	45305	Colonoscopy and polypectomy in 53 year old male with 2 colon polyps, outpatient procedure.	120.0	306.0	434.0	A
1	X	93503	Insertion of Swan-Ganz catheter.	259.0	153.0	412.0	A
1	"	49505	Uncomplicated indirect inguinal hernia repair, 45 year old male.	102.0	237.0	419.0	B
1	A	43110	Total esophagectomy with gastroesophageal anastomosis in chest.	1259.0	1491.0	2750.0	B
1	D	19240	Modified radical mastectomy.	568.0	631.0	1199.0	B
1	E	31603	Tracheostomy, emergency procedure, transtracheal, in adult, for partial airway obstruction, post trauma.	136.0	270.0	406.0	B
1	F	42820	Tonsillectomy and adenoidectomy in 10 year old child.	234.0	148.0	382.0	B
1	G	44145	Low anterior resection for rectal carcinoma.	669.0	979.0	1648.0	B
1	H	44950	Appendectomy for acute abdomen with unperforated appendicitis.	302.0	272.0	574.0	B
1	K	47600	Cholecystectomy for cholelithiasis.	397.0	406.0	803.0	B
1	L	58150	Abdominal hysterectomy for cancer in situ of cervix in 50 year old woman.	465.0	407.0	872.0	B
1	M	64721	Decompression of carpal tunnel in 48 year old female, unilateral, ambulatory surgery unit.	190.0	164.0	354.0	B
1	N	67840	Excision of 0.5 cm basal cell carcinoma on the outer 1/3 of the lower eyelid.	.	.	120.0	C
1	Y	99160 99162	Triage, resuscitation and hospital admission from ER (emergency room), prior to consultation/intervention, of 52 year old, new patient, alcoholic male with ascites, jaundice, encephalopathy, and massive hematemesis.	.	.	208.0	C

List of cross-specialty links: Hematology/Oncology

Link	Sp	Svc*	Ph*	Service description	Type of link**	Mean service time
va05	ho	ac	2	Initial abdominal paracentesis.	I	29
ga		as	2	Initial abdominal paracentesis.		24
bc25	ho	af	2	Initial office consultation for an 80-year-old male with newly diagnosed adenocarcinoma of the prostate and negative metastatic work-up.	I	45
ro		ao	2	Initial office consultation for an 80-year-old male with newly diagnosed adenocarcinoma of the prostate and negative metastatic work-up.		50
va39	ho	af	2	Initial office consultation for an 80-year-old male with newly diagnosed adenocarcinoma of the prostate and negative metastatic work-up.	w	45
id		am	2	Initial office consultation for a 65-year-old female with persistent bronchitis.		36
ba30	ho	al	2	Follow-up office visit for a stable 50-year-old female with metastatic breast cancer.	t	17
nu		af	2	Thyroid imaging only (no uptake) in a female with a palpable thyroid nodule; first examination.		22
vb02	ho	ak	2	Initial thoracentesis.	I	31
pu		am	2	Initial thoracentesis.		30
vc02	ho	ak	2	Initial thoracentesis.	I	31
ld		aj	2	Initial thoracentesis.		25
ba33	ho	al	2	Initial office consultation for a second opinion regarding initial therapy for a 32-year-old patient with biopsy-proven Hodgkin's lymphoma.	I	55
ro		ap	2	Initial office consultation for discussion of treatment options for a 40-year-old female with a two-centimeter adenocarcinoma of the breast.		62

APPENDIX D

**MATERIALS MAILED TO SPECIALTY
SOCIETIES TO REVIEW
RADIOLOGY RWVs**

INSTRUCTIONS

This mailout will provide your society with an opportunity to review and comment on Radiologist Fee Schedule (RFS) values and Hsiao values for imaging services. Please read these instructions carefully before you begin. If you have any questions, feel free to call Vicky Pebsworth at (202) 653-7220.

I. METHOD USED TO LINK THE RFS TO HSIAO'S COMMON SCALE

To make it easier for you to compare RFS values with Hsiao values for imaging services and to relate RFS values to values for non-imaging services, we linked the RFS to Hsiao's common scale. To do this, we used a method based on the one HCFA suggested in its Model Fee Schedule for Physicians' Services. This method is described below:

- (1) Professional component values in the RFS were considered equivalent to physician total work values in the Hsiao study.¹ (For imaging services, the professional component is the professional service provided by the physician, while the technical component includes the specialized supplies, equipment, and staff that are necessary to do the service).
- (2) For each of the imaging services surveyed in the Hsiao study, we calculated the ratio of Hsiao's physician total work value to the RFS professional component value.
- (3) We then weighted each ratio by multiplying it by the total allowed charges for that service.
- (4) The sum of weighted ratios for all surveyed imaging services was then divided by the sum of the total allowed charges for all surveyed imaging services. This is the imaging conversion factor (ICF):

$$\text{ICF} = \frac{\sum [(\text{Hsiao total work/RFS professional component}) \times \text{allowed charges}]}{\sum (\text{allowed charges})}$$

- (5) The RFS was linked to Hsiao's common scale by multiplying each RFS value by the imaging conversion factor.

Since the Commission has not yet developed its recommendations for the method that should be used to link the RFS to Hsiao's common scale, we would welcome any comments you may have about the above method or alternative methods.

¹ Hsiao values are those assigned in the final report of Phase II of the Hsiao study (see Table 12.2). (This table contains values for imaging services surveyed in both Phases I and II).

II. VALUES FOR IMAGING SERVICES SURVEYED IN YOUR SPECIALTY

We are enclosing a list of RFS values and Hsiao values for all imaging services surveyed in your specialty. (Since not all specialties were surveyed for imaging services in the Hsiao study, only the following specialties are receiving these lists: diagnostic radiology, radiation oncology, nuclear medicine, dermatology, obstetrics/gynecology, ophthalmology, oral and maxillofacial surgery, orthopedic surgery, pulmonary medicine, rheumatology and neurology).

Each surveyed imaging service is identified by its descriptive vignette, the identifier letter assigned to it in the Hsiao study, the CPT code to which it was assigned, and the phase of the Hsiao study in which it was surveyed. The RFS and Hsiao values are on a common scale and both reflect the work involved in providing the professional component of the imaging service.

Since the legislation specifies that the Medicare Fee Schedule values for imaging services will be based on the RFS, we only want you to comment about imaging services with RFS values that you consider to be inaccurate. Please use IMAGING RESPONSE FORM A: FOR SERVICES SURVEYED IN YOUR SPECIALTY for this purpose.

For each form you fill out, please identify your society, the specialty you represent, and the service in question (by code and vignette). In the space provided, indicate what you believe would be a more accurate estimate of relative work for the service (either the Hsiao value or another work value) and then write a concise discussion of the underlying problem, attaching any supporting data that substantiates your claim.

Try to be specific about any problems you identify. For example, let us know if your concern is related to the relationship between the RFS value for the imaging service in question and other imaging services, the relationship between the RFS value for the imaging service in question and non-imaging services, issues related to the professional and technical components of the imaging service, etc.

If you wish to provide the Commission with general comments that apply to more than one vignette, please feel free to do so.

III. RWVs FOR IMAGING SERVICES NOT SURVEYED IN YOUR SPECIALTY

In this mailout, we are also enclosing a Master List of relative work values (RWVs) for all imaging services. Each imaging service is identified by its CPT code, its CPT descriptor, its RFS value on the Hsiao common scale, and its Hsiao RWV (if the service was surveyed in the Hsiao study).

Please review the Master List for all imaging services your specialty provides. If you believe the RFS value is inaccurate for an imaging service your specialty provides that was not surveyed by Hsiao, please comment using IMAGING RESPONSE FORM B: FOR SERVICES NOT SURVEYED IN YOUR SPECIALTY.

For each form you fill out, please identify your society, the specialty you represent, and the CPT code for the service in question. In the space provided, indicate what you believe would be a more accurate estimate of relative work for the service (either the Hsiao value if applicable or another work value) and then write a concise discussion of the underlying problem, attaching any supporting data that substantiates your claim.

We look forward to receiving your comments about the method for linking the RFS to Hsiao's common scale and about inaccurate RFS values. Please provide your comments on a rolling basis, but no later than **February 11, 1991**.

**IMAGING RESPONSE FORM A
FOR SERVICES SURVEYED IN YOUR SPECIALTY**

Specialty Society : _____ Date : _____

Specialty : _____

CPT code : _____ Vignette: _____

By completing this form you are questioning the accuracy of the Radiologist Fee Schedule work value.

You believe a more accurate work value would be: ☐ Hsiao value
☐ Other work value : _____

Concisely state what you believe to be the problem(s) with the assigned work value and **provide supporting documentation** that substantiates your claim. Attach additional pages if necessary.

**IMAGING RESPONSE FORM B
FOR SERVICES NOT SURVEYED IN YOUR SPECIALTY**

Specialty Society : _____ Date : _____

Specialty : _____

CPT code : _____

By completing this form you are questioning the accuracy of the Radiologist Fee Schedule work value.

You believe a more accurate work value would be: ☐ Hsiao value (if applicable)
☐ Other work value : _____

Concisely state what you believe to be the problem(s) with the assigned work value and **provide supporting documentation that substantiates your claim. Attach additional pages if necessary.**

SPECIALTY - DIAGNOSTIC RADIOLOGY

VIGNETTE				COMMENT USING		
PHASE	CODE	CPT-4 MOD	VIGNETTE DESCRIPTION	RFS	HSIAO	IMAGING RESPONSE FORM:
1	K	72140 26	Magnetic resonance imaging of the spinal cord, including spine, for unexplained onset of motor weakness in lower extremities, performance and interpretation.	.	179	A
1	L	74020 26	Interpretation of complete abdomen, including decubitus and/or erect views, for questionable intestinal obstruction.	23	27	A
1	M	74400 26	Intravenous urography, pyelography, including kidneys, ureters, and bladder, in patient with hematuria and flank pain, performance and interpretation.	43	77	A
1	N	75821 26	Venography, unilateral, complete procedure, for possible deep vein thrombosis of lower extremity, performance and interpretation.	105	122	A
1	O	70260 26	Interpretation of complete skull series for headaches in an adult.	29	25	A
1	P	78351 26	Interpretation of bone density study, dual photon absorptiometry of spine for possible osteoporosis.	21	33	A
1	Q	72110 26	Interpretation of lumbar spine x-rays, complete radiograph exam in an adult patient with low back pain.	26	28	A
1	R	74741 26	Hysterosalpingography, complete procedure, in 26 year old woman with infertility.	90	106	A
1	S	72266 26	Performing and interpreting a lumbar myelogram, 68 year old female.	175	218	A
1	T	73510 26	Interpretation of hip x-rays, complete, for moderate/severe hip pain.	18	22	A

MASTER LIST

RELATIVE WORK VALUES FOR ALL IMAGING SERVICES

CPT4	MOD	DESCRIPTION	RFS	HSIAO
70010	26	CONTRAST X-RAY OF BRAIN	103	.
70011	26	CONTRAST X-RAY OF BRAIN	206	.
70015	26	CONTRAST X-RAY OF BRAIN	103	.
70016	26	CONTRAST X-RAY OF BRAIN	206	.
70030	26	X-RAY EYE FOR FOREIGN BODY	15	.
70100	26	X-RAY EXAM OF JAW	16	.
70110	26	X-RAY EXAM OF JAW	21	.
70120	26	X-RAY EXAM OF MASTOIDS	16	.
70130	26	X-RAY EXAM OF MASTOIDS	29	.
70134	26	X-RAY EXAM OF MIDDLE EAR	29	.
70140	26	X-RAY EXAM OF FACIAL BONES	16	.
70150	26	X-RAY EXAM OF FACIAL BONES	22	.
70160	26	X-RAY EXAM OF NASAL BONES	15	.
70170	26	X-RAY EXAM OF TEAR DUCT	25	.
70171	26	X-RAY EXAM OF TEAR DUCT	78	.
70190	26	X-RAY EXAM OF EYE SOCKETS	18	.
70200	26	X-RAY EXAM OF EYE SOCKETS	24	.
70210	26	X-RAY EXAM OF SINUSES	15	.
70220	26	X-RAY EXAM OF SINUSES	21	.
70240	26	X-RAY EXAM PITUITARY SADDLE	17	.
70250	26	X-RAY EXAM OF SKULL	21	.
70260	26	X-RAY EXAM OF SKULL	29	25
70300	26	X-RAY EXAM OF TEETH	3	.
70310	26	X-RAY EXAM OF TEETH	13	.
70320	26	FULL MOUTH X-RAY OF TEETH	19	.
70328	26	X-RAY EXAM OF JAW JOINT	16	.
70330	26	X-RAY EXAM OF JAW JOINTS	21	61
70332	26	X-RAY EXAM OF JAW JOINT	48	.
70333	26	X-RAY EXAM OF JAW JOINT	130	.
70350	26	X-RAY HEAD FOR ORTHODONTIA	14	.
70355	26	PANORAMIC X-RAY OF JAWS	17	22
70360	26	X-RAY EXAM OF NECK	15	.
70370	26	THROAT X-RAY & FLUOROSCOPY	27	.
70371	26	SPEECH EVALUATION, COMPLEX	73	.
70373	26	CONTRAST X-RAY OF LARYNX	33	.
70374	26	CONTRAST X-RAY OF LARYNX	97	.
70380	26	X-RAY EXAM OF SALIVARY GLAND	15	.
70390	26	X-RAY EXAM OF SALIVARY DUCT	32	.
70391	26	X-RAY EXAM OF SALIVARY DUCT	85	.
70450	26	CAT SCAN OF HEAD OR BRAIN	74	.
70460	26	CONTRAST CAT SCAN OF HEAD	97	.
70470	26	CONTRAST CAT SCANS OF HEAD	110	39
70480	26	CAT SCAN OF SKULL	111	.
70481	26	CONTRAST CAT SCAN OF SKULL	120	.
70482	26	CONTRAST CAT SCANS OF SKULL	126	.
70486	26	CAT SCAN OF FACE, JAW	98	.
70487	26	CONTRAST CAT SCAN, FACE/JAW	112	.
70488	26	CONTRAST CAT SCANS FACE/JAW	123	.
70490	26	CAT SCAN OF NECK TISSUE	111	.
70491	26	CONTRAST CAT OF NECK TISSUE	120	.

APPENDIX E

CPT CODES FOR RWVs DISPUTED BY SOCIETIES, BY TYPE OF SERVICE

Appendix E. CPT Codes for RWVs Disputed by Societies, By Type of Service

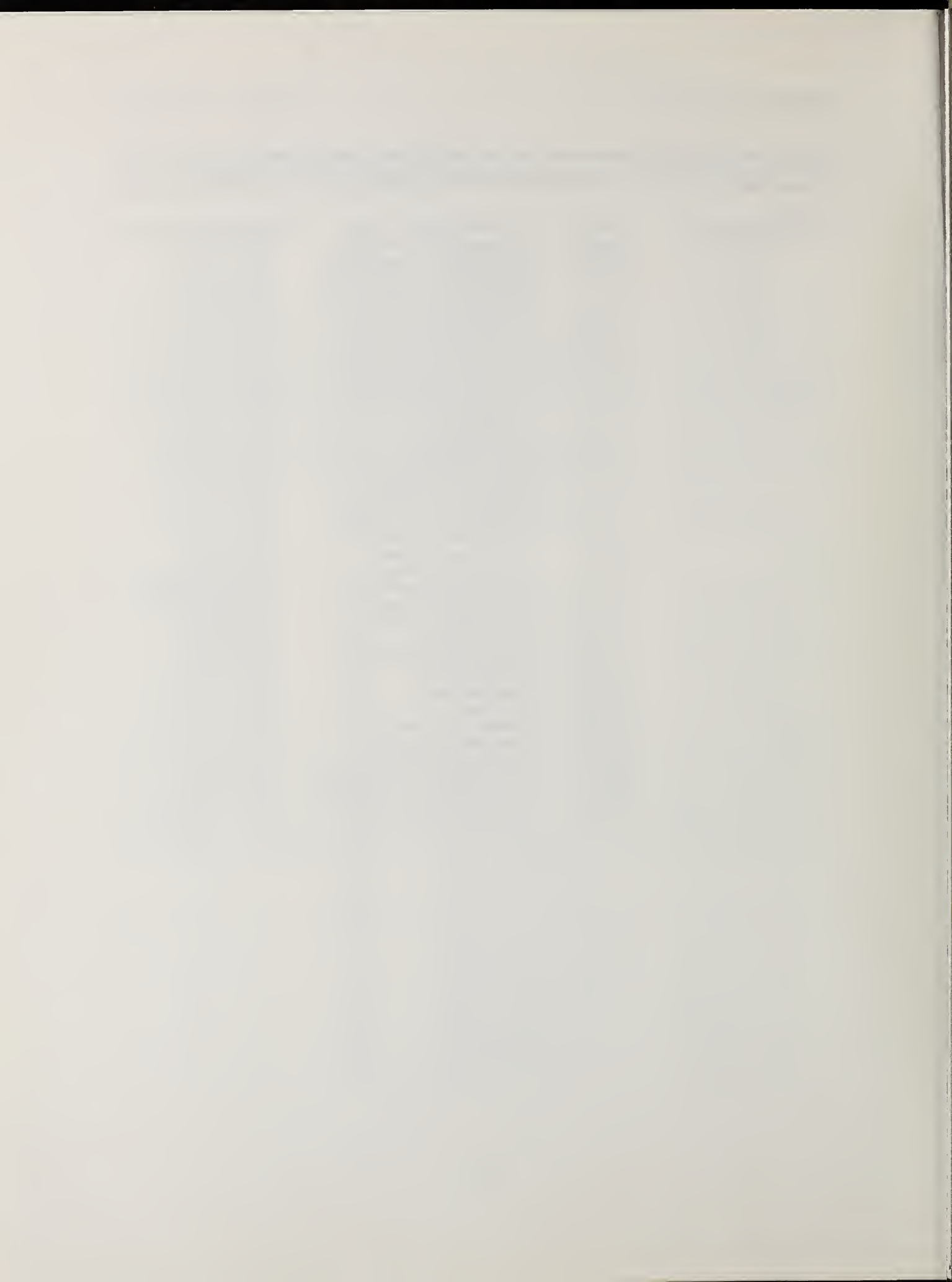
	CPT CODE	DESCRIPTOR	COMMENTS
LABORATORY SERVICES	80500	Lab Pathology Consultation	RWV is too low
	80502	Lab Pathology Consultation	RWV is too low
	85060	Blood Smear Interpretation	No consensus
	85097	Bone Marrow Interpretation	No consensus
	85100	Bone Marrow Examination	No consensus
	85105	Bone Marrow, Interpretation	RWV is too low
	88104	Cytopathology	RWV is too low
	88302	Surgical Pathology, Complete	RWV is too low
	88305	Surgical Pathology, Complete	No consensus
	88309	Surgical Pathology, Complete	RWV is too low
	88331	Consultation During Surgery	RWV is too low
	88332	Consultation During Surgery	RWV is too low
	89320	Semen Analysis	No consensus
	93309	Echo Exam of Heart	RWV is too low
	93870	Carotid Artery Imaging	No consensus
	94060	Bronchospasm Evaluation	RWV is too low
	95819	Electroencephalogram	RWV is too low
DIAGNOSTIC PROCEDURES	62270	Spinal Fluid Tap, Diagnostic	No consensus
	93503	Right Heart Catheterization	No consensus
	95860	Electromyography, One Limb	No consensus
	95900	Motor Nerve Conduction Test	No consensus
	95904	Sensory Nerve Conduction Test	No consensus
TECHNICAL PROCEDURES	11440	Removal of Skin Lesion	No consensus
	11600	Removal of Skin Lesion	RWV is too low
	11601	Removal of Skin Lesion	RWV is too low
	11602	Removal of Skin Lesion	RWV is too low
	11621	Removal of Skin Lesion	RWV is too low
	11622	Removal of Skin Lesion	RWV is too low
	11623	Removal of Skin Lesion	RWV is too low
	11640	Removal of Skin Lesion	RWV is too low
	11641	Removal of Skin Lesion	RWV is too low
	11642	Removal of Skin Lesion	RWV is too low
	12002	Repair Superficial Wound(s)	No consensus
	12011	Repair Superficial Wound(s)	No consensus
	20610	Inject/Drain Joint/Bursa	No consensus
	29405	Apply Short Leg Cast	No consensus
	30901	Control of Nosebleed	RWV is too low
	31032	Explore Sinus, Remove Polyps	No consensus
	31500	Insertion of Windpipe Airway	No consensus
	31603	Incision of Windpipe	RWV is too low
	32000	Drainage of Chest	No consensus
	33010	Drainage of Heart Sac	RWV is too low
	33210	Insertion of Heart Electrode	RWV is too high
	36489	Insertion of Catheter, Vein	No consensus
	43204	Esophagus Endoscopy and Inject	No consensus
	43235	Upper GI Endoscopy, Diagnosis	No consensus
	43239	Upper GI Endoscopy, Biopsy	No consensus
	43246	Operative Upper GI Endoscopy	No consensus

Appendix E. continued

	CPT CODE	DESCRIPTOR	COMMENTS
TECHNICAL PROCEDURES	43255	Operative Upper GI Endoscopy	No consensus
	43260	Endoscopy, Bile Duct/Pancreas	No consensus
	43262	Endoscopy, Bile Duct/Pancreas	No consensus
	43450	Dilate Esophagus	No consensus
	45300	Proctosigmoidoscopy	No consensus
	45330	Sigmoidoscopy	No consensus
	45331	Sigmoidoscopy and Biopsy	No consensus
	45378	Diagnostic Colonoscopy	No consensus
	45380	Colonoscopy and Biopsy	No consensus
	45385	Colonoscopy, Lesion Removal	RWV is too low
	50200	Biopsy of Kidney	RWV is too low
	52000	Cystoscopy	RWV is too low
	62278	Inject Spinal Anesthetic	RWV is too low
	62284	Injection for Myelogram	RWV is too low
	65222	Remove Foreign Body from Eye	No consensus
	67840	Remove Eyelid Lesion	RWV is too low
	69200	Clear Outer Ear Canal	No consensus
	92982	Coronary Artery Dilation	RWV is too low
	93536	Insert Circulation Assist	RWV is too high
SURGICAL GLOBAL SERVICES	11606	Removal of Skin Lesion	RWV is too low
	11644	Removal of Skin Lesion	RWV is too low
	15100	Skin Split Graft Procedure	RWV is too low
	19120	Removal of Breast Lesion	RWV is too low
	19240	Extensive Breast Surgery	RWV is too low
	20680	Removal of Support Implant	No consensus
	21200	Reconstruct Lower Jaw Bone	RWV is too low
	21250	Reconstruct Facial Bone(s)	RWV is too low
	21320	Treatment of Nose Fracture	RWV is too high
	21365	Repair Cheek Bone Fracture	RWV is too low
	21470	Repair Lower Jaw Fracture	RWV is too low
	25611	Repair Fracture Radius/Ulna	No consensus
	26122	Revision of Palm Contracture	No consensus
	27236	Repair of Femur Fracture	No consensus
	27244	Repair of Femur Fracture	No consensus
	27590	Amputate Leg at Thigh	No consensus
	30420	Reconstruction of Nose	RWV is too low
	31535	Operative Laryngoscopy	RWV is too low
	32020	Treatment of Collapsed Lung	No consensus
	32480	Partial Removal of Lung	RWV is too high
	33207	Insertion of Heart Pacemaker	RWV is too low
	33405	Replacement of Aortic Valve	RWV is too low
	33512	Coronary Arteries Bypass	RWV is too low
	33681	Repair Heart Septum Defect	RWV is too low
	34201	Removal of Artery Clot	RWV is too low
	35081	Repair Defect of Artery	RWV is too low
	35301	Rechanneling of Artery	RWV is too low
	35656	Artery Bypass Graft	RWV is too low
	36830	Artery-Vein Graft	RWV is too low

Appendix E. continued

	CPT CODE	DESCRIPTOR	COMMENTS
SURGICAL GLOBAL SERVICES	38100	Removal of Spleen, Total	RWV is too low
	39400	Visualization of Mediastinum	RWV is too high
	42145	Repair, Palate, Pharynx/Uvula	RWV is too low
	42820	Remove Tonsils and Adenoids	RWV is too low
	43110	Partial Removal of Esophagus	RWV is too low
	43630	Partial Removal of Stomach	RWV is too low
	43830	Surgical Opening of Stomach	RWV is too low
	44005	Freeing of Bowel Adhesion	RWV is too low
	44120	Removal of Small Intestine	RWV is too low
	44140	Partial Removal of Colon	RWV is too low
	44145	Partial Removal of Colon	RWV is too low
	44320	Colostomy	RWV is too low
	44950	Appendectomy	No consensus
	45110	Removal of Rectum	RWV is too low
	46260	Hemorrhoidectomy	RWV is too low
	47600	Removal of Gallbladder	RWV is too low
	47605	Removal of Gallbladder	RWV is too low
	47760	Fuse Bile Ducts and Bladder	RWV is too low
	49000	Exploration of Abdomen	RWV is too low
	49505	Repair Inguinal Hernia	No consensus
	49520	Repair Inguinal Hernia	RWV is too low
	49560	Repair Abdominal Hernia	RWV is too low
	52235	Cystoscopy and Treatment	No consensus
	52601	Prostatectomy (TURP)	No consensus
	58150	Total Hysterectomy	No consensus
	58982	Laparoscopy; Tubal Cautery	RWV is too low
	59410	Obstetrical Care	RWV is too low
	59500	Cesarean Section	RWV is too low
	59840	Abortion	RWV is too low
	60500	Explore Parathyroid Glands	RWV is too low
	61526	Removal of Brain Lesion	RWV is too low
	63030	Low Back Disk Surgery	No consensus
	64721	Revise Median Nerve at Wrist	No consensus
	69641	Revise Middle Ear and Mastoid	RWV is too low
	69930	Implant Cochlear Device	RWV is too low





[illegible]